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HEALTH CARE LEGISLATION AND THE IMPLIED US HEALTH CARE POLICY
THROUGH 1992

An examination of health care legislation in the United States from 1798 through 1992 to review the role of government in developing our current system of health care

by

Lieutenant Colonel Gary N. Matteson
USAWC Army SSC Fellow
US Department of Health and Human Service

Colonel Steven A. Raho III
USAWC SSC Fellowship Program Director

U.S. Army War College
Carlisle Barracks, Pennsylvania 17013

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ABSTRACT

AUTHOR: Gary N. Matteson (LTC), USA

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For the last twenty years, the term crisis, has consistently been used to describe the American health care system. This paper reviews the developments in US health care legislation with the intent of answering the question, Do we have a national health care policy? As preparations for another presidential election are underway, it is important to reflect back on the political importance of health care in the United States. A major tool in President Clinton's successful campaign was the pledge to reform health care in this country and make it accessible for all Americans. The Republican Revolution sought to rein in the costs of Medicare and Medicaid in order to ensure balancing the budget by 2002. Currently there is a proposal in Congress to increase the "portability" of health care insurance when an individual is between jobs. With all of the debate that has transpired, little has been done. The country's health care expenditures continue to rise, we still have a maldistribution of health care resources, limited access for many people, and the number of uninsured continues to rise. These problems have been persistent for the last 50 years. How did this happen?

In trying to explore these issues, this paper takes a historical view of health care politics from 1798 to 1992.

Introduction

For the last twenty years, the term crisis, has frequently been used to describe the American health care system. This paper reviews the developments in US health care legislation with the intent of answering the question, Do we have a national health care policy? As preparations for another presidential election are underway it is important to reflect back on the political importance of health care in the United States. A major tool in President Clinton's successful campaign was the pledge to reform health care in this country and make it accessible for all Americans. The Republican Revolution sought to rein in the costs of Medicare and Medicaid in order to ensure balancing the budget by 2002. Currently there is a proposal in Congress to increase the "portability" of health care insurance when an individual is between jobs. With all of the debate that has transpired, little has been done. The country's health care expenditures continue to rise, we still have a maldistribution of health care resources, limited access for many people, and the number of uninsured continues to rise. These problems have been persistent for the last 50 years. How did this happen?

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Body

The first health care legislation enacted in the United States was the creation of the Marine Hospital Service in 1798 by the 5th Congress. America was dependent on the sea and the legislation arose out of the concern that mariners might spread disease to the rest of the population. To decrease this risk, Congress recognized the need to screen for illness and provide general health care to the merchant seaman. This program was financed by deductions from the seamen's wages (In 1912 the Marine Hospital Service was renamed the Public Health Service [PHS]).

In the early years of the United States, health care was viewed as an individual responsibility and the practice of medicine was highly variable and minimally effective. Cleanliness and quarantine offered the best public health protection. The federal government played very little in the development of health care or its financing. The early activities dealing with health care were all in the private sector. The Massachusetts Health Insurance Company in Boston offered the first commercial health insurance product in 1847. The program was identified as "sickness insurance." In 1851 a mutual protective society for health care was formed in San Francisco. The first group health insurance was offered in 1910 when Montgomery Ward converted from an employee mutual benefit society and contracted with a commercial insurance carrier. The only federal activity dealing with health care in this time frame was the creation of the Hygienic Laboratory by the 50th Congress in 1887. The Hygienic Laboratory was later named the National Institutes of Health in 1930.

In Europe during the late 1800s and early 1900s there had been tremendous national activity in health care. By 1913 all the major European countries had enacted national health legislation. In the US there was no federal activity towards compulsory health insurance. Programs of social welfare were considered the responsibility of the state and not the realm of the federal government. In 1912, national health insurance was advocated by the Progressive Party and it was part of the platform for their unsuccessful presidential candidate, former President Theodore Roosevelt. In 1915 some Progressive era activists advocated federal reform of the health care system. They proposed employers, workers, and government should share in the cost of an integrated system for employees that would emphasize disease prevention rather than cure. This was a part of the Progressive's larger goal of strengthening federal government, but related legislation was never passed. These proposals only covered the employed.

At approximately the same time there was some state activity in health care. In 1916 sixteen state legislatures considered a health insurance plan that was sponsored by the American Association for Labor Legislation (AALL). It is interesting to note that the American Medical Association (AMA), later known for its opposition to many health insurance proposals, and the AALL had worked together on this effort. There had been some effort to include a capitated method of payment and price controls but the AMA's efforts insured that the legislation included a fee for service payment system and retained physician autonomy. The opposition to the proposals came from both business and labor. Business felt that it would increase expenses and de-emphasize the need to work. Labor also opposed the plan even though they had originally worked with the AALL to create the legislation. The change of mind occurred because labor leader Sam Gompers feared that if health insurance was provided by the state, instead of from union membership, it would seriously weaken the incentive to join and organize unions. The insurance industry was very active in opposing this legislative effort.

In 1918 compulsory health insurance was voted on by referendum in California and it was soundly defeated. Much had changed since 1915. The US had entered World War II and much of the physician support for insurance had evaporated as more and more doctors looked at government sponsored health insurance as a threat to their livelihoods and a government attempt to control the practice of medicine. A physician group in California, opposed to compulsory health insurance, advertised it as something created by the German Emperor in his attempt to dominate the world. After the war, programs of social reform became linked to the red scare.

In 1926 a privately funded commission was formed, called the Committee on the Costs of Medical Care (CCMC). Physicians were recognized as a powerful force and to assure adequate representation on the committee, the organizers appointed 18 physicians out of a total membership of 50. Past president of the AMA and a prominent member of the Republican Party, Lyman Wilbur was appointed Chairman. The committee spent five years

studying the various aspects of medicine in the US and produced a comprehensive picture. The final recommendations of the committee were very controversial and there had been significant disagreement within the committee. The majority of the committee recommended group practice and group payment mechanisms, avoiding competition in medicine, expanding the role of the government in medical care for the indigent, supported voluntary insurance, and opposed compulsory insurance. The minority opinion was strongly opposed to the concepts of group medicine and opposed voluntary insurance because of the fear it would lead to compulsory insurance. The AMA supported the minority view and strongly denounced the CCMC's recommendations.

An innovative approach to health care, the nation's first HMO, the Ross Loos Clinic opened its doors in Los Angeles, California in 1929. For just \$2 a month each worker and their family were covered for both hospitalization and outpatient care. Three years later, in 1932, a group of hospitals in Sacramento banded together and initiated the first citywide Blue Cross Blue Shield plan.

The Depression placed significant strain on doctors to provide care to the impoverished. In prior times when doctors were receiving reimbursement from most of their other patients, they were able to provide care to the poor. During the depression when many individuals had trouble paying, this form of cost shifting could not occur and physicians took reimbursement from welfare departments. The AMA looked at this willingness to accept payments from federal, state, and local agencies as government intervention and feared it would lead to government domination of medicine.

The Depression brought social insurance to national attention. The roles of the federal government had dramatically increased and no longer were states expected to provide all of the social protection for the individual citizen. The Depression emphasized the urgent need for unemployment insurance and old age assistance while health insurance was lower on the priority list. In 1935 President Roosevelt appointed a Committee on Economic Security and their recommendations formed the basis of the Social Security Act (SSA). Health insurance was quickly recognized as a very controversial agenda item and it was strongly opposed by the medical profession. The committee's final report recommended a limited form of compulsory national health insurance, but Roosevelt never released the final report. The Roosevelt administration was unwilling to place health insurance on their legislative agenda, knowing that including it in the SSA would endanger passage of the more limited proposal. An additional factor of concern to the administration was the inadequate number of medical facilities and providers in the US to support a federal insurance program. For national health insurance to have any chance for success, the underlying medical structure needed to be in place before legislation should be passed.

Even though national health insurance was not included in the SSA, it did mark the beginning of a piece meal approach to federal funding of health care. The health care programs included were federal financing of medical benefits for the

elderly and the authorization of matching grants, awarded to the states for: expectant mothers and children, crippled children, and for general public health work. Supervision of these grants was given to the Surgeon General of the PHS. This established a pattern of health care funding that did not interfere with the professional control of medicine but did support the expansion.

The 75th Congress(1937-38) authorized grants to control specific diseases; venereal disease, tuberculosis, mental illness, cancer ,and heart disease. This Congress also passed the National Cancer Act that created the National Cancer Institute(NCI). The act funded the NCI to carry out research in it own institution but also to oversee research grants that given to individuals and institutions. The NCI was the first of the "specialized" institutes in the National Institute of Health.

During World War II, group health programs became a very important tool in labor's collective bargaining. Both labor and business considered health coverage to be an effective tool to bring in and keep employees when wages were frozen. To make this benefit even more attractive, it was not taxed.

The cost of health care was beginning to be an issue in the early 1940s. To protect those with large medical outlays, the Revenue Act of 1942 made health care expense a taxable deduction but only when they were in excess of 5% of total income.

In 1943, Senators Wagner (Dem., NY) Murray (Dem., MN) and Dingell (Dem., MI) introduced a bill that would have broadened the Social Security Act to include a compulsory national health insurance. Their proposal was to be financed by a federal payroll tax. The preamble to the bill read:

"To provide for the general welfare; to alleviate the economic hazards of old age, premature death, disability, sickness, unemployment, and dependency; to amend and extend the provisions of the Social Security Act; to establish a Unified National Social Insurance System; to extend the coverage, and to protect and extend the social security rights of individuals in the military service; to provide insurance benefits for workers permanently disabled; to establish a Federal system of unemployment compensation, temporary disability, and maternity benefits; to establish a national system of public employment offices; to establish a Federal system of medical and hospitalization benefits; to encourage and aid the advancement of knowledge and skill in the provision of health services and in the prevention of sickness, disability, and premature death; to enable the several States to make more adequate provision for the needy aged, the blind, dependent children, and other needy person; to enable the States to establish and maintain a comprehensive public assistance program; and to amend the Internal Revenue Code."

In 1943 there was little congressional activity on this bill but it aroused tremendous concern among the medical profession and

big business. It was called "socialized medicine" and it would "destroy" American medicine.

During the same year, Congress passed legislation to deal with the wartime shortage of nursing personnel. Sixty million dollars a year was authorized to schools of nursing to increase the production of nurses. This was the first large scale program to support the training of health professionals. As with most of the health care legislation passed, it had few federal requirements.

During Presidents Roosevelt's 1944 State of the Union Address, he proposed an economic bill of rights that included the right to adequate medical care and the opportunity to achieve and enjoy good health. He did not follow this with specific enabling legislation. In that same year, when the Social Security Board met, they recommended the adoption of national health insurance.

Congress did pass the Public Health Service Act of 1944 consolidating everything that dealt with the PHS into one bill. This Act also began an expansion of the role of the PHS. The prewar responsibilities of the PHS had been to: 1) provide direct medical care to specific groups the federal government had responsibility for, 2) to conduct research into causes and cures of disease including environmental health, and 3) to control and eradicate mass diseases. None of these areas represented a threat to private medicine. After the war the role of the PHS was rapidly expanded to: 1) training of health professionals, 2) construction of hospitals and medical and research facilities, 3) expansion of its role in working with states and a rapid increase in funding to the states, and 4) expansion of its role in providing grants. The predominant function of all of this money was to increase services, increase construction of medical facilities, and increase the numbers of trained medical professionals with little although now there was some, federal control.

In 1945, in his last State of the Union Address, Roosevelt again referred to the right for good medical care, but once more no specific proposals followed. Wagner, Murray and Dingell reintroduced their proposal that sparked little activity.

During that year a modest program was passed that authorized federal agencies to provide minor medical and dental services to their employees. This was the first time that federal civilian employees had received medical benefits. As modest as it was, its passage still served to raise significant concern that the language in this bill would lead to socialized medicine.

After Roosevelt's demise, President Truman proposed raising the Social Security Tax by 4% and using the proceeds to fund a comprehensive prepaid medical insurance plan to cover all citizens. His proposals covered doctor, hospital, nursing, laboratory and dental costs. In his original recommendations, needy persons were to be covered by payments from general federal revenues. He stressed that the plan was not socialized medicine because there was freedom to choose physicians and that the physicians were not government employees. Although it was recognized that health care was becoming more expensive, under-

spending was a bigger concern. Truman noted that the country was only spending 4% of its GNP on health care and he stated we should be spending more.

After President Truman's statement, Senators Wagner, Murray, and Dingell promptly introduced the Truman proposals to Congress. In 1946 Sen. Taft (Rep, OH) called the bill "the most socialistic measure that this Congress has ever had before it." Taft countered with a proposal authorizing 230 million a year in federal grants to the states to enable them to provide comprehensive medical care for persons unable to pay for it. The Taft bill also permitted states to use some of the grant to pay partial health insurance premiums for low income individuals who were not below the federal poverty line. The AMA endorsed Taft's proposal. Hearings were held on both bills, but neither was acted on by Congress.

Although no health insurance proposals were passed, Congress did work to increase the medical infrastructure in the country. In 1946 the "Hill-Burton Act" or the Hospital Survey and Construction Act authorized 75 million to public and private nonprofit corporations for hospital construction. Since the depression, no new hospitals had been built and existent ones had not been upgraded. The legislation was enacted to correct this problem. The funding formula was \$3 of local money for every \$2 of federal funds. The administration of the plan was left to the states so there was little federal control. The bill passed with wide support.

During the 80th Congress (1947-48), President Truman again requested; and Senators Wagner, Murray, and Dingell reintroduced national health insurance to Congress. Sen. Taft re-countered with his proposal but no action was taken in the Republican controlled House and Senate. The expense of health care was continuing to rise so Congress did amend the income tax law to allow for an increase in the deduction for medical expenses. These income tax changes lessen the individual burden of increased health care costs, but they also tend to add a little fuel to the fire.

In 1949, the passage of national health insurance appeared likely. There was a Democrat in the White House and both chambers were controlled by Democrats. A coalition of organized labor, northern Democratic Congressmen, and "liberal" organizations pushed for compulsory federal health insurance that would cover all Americans regardless of age or means. Labor leaders were no longer concerned that a government program of health insurance would decrease their ability to attract members. President Truman in his State of the Union Address called for compulsory universal national health insurance to be financed by a federal payroll tax. Senators Wagner, Murray, and Dingell once again reintroduced the legislation. Campaigning for the Truman proposals were the, AFL/CIO, Americans for Democratic Action, Physicians Forum, National Farmers Union, American Veterans Committee, Consumers Union, the railroad unions, the American Association of Social Workers, and a group of prominent Americans known the Committee for the Nation's Health.

The leading opponent was the AMA, but it was not alone. Others joining in to oppose the legislation were the American Dental Association, American Pharmaceutical Assn., Blue Cross-Blue Shield Commissions, Chamber of Commerce, American Legion, American Farm Bureau Federation, National Grange, General Federation of Women's Clubs, Health Insurance Council, Health and Accident Underwriters Conference, and the National Catholic Welfare Conference. A lot of debate occurred but the opposition to national health insurance prevailed and the bill was never referred out of committee.

On the spending side of health care, the 81st Congress did review the Hill-Burton Act and increased the federal funding for the program because more hospitals were needed.

In 1950 Truman again moved for compulsory health insurance and still again, his efforts were blocked. That same year, Congress did review the health care support to the needy. The result was amending the Social Security Act so that federal funds were given to the states to provide medical care to the individuals covered by the four Public Assistance programs for the indigent; Old Age Assistance, Aid to Dependent Children, Aid to the Blind, and Aid to the Permanently and Totally Disabled. Prior to these amendments, federal and state governments had shared in making monthly payments to cover living expenses, directly to the recipients. With these new amendments, in addition to the direct payments to recipients, payments were made to "vendors" such as hospitals and doctors. This change significantly increased both the state and federal outlay of dollars.

In 1951 the 82nd Congress chose once again to change the income tax laws. Individuals over 65 were now permitted to deduct 100% of their medical expenses. All other groups could still only deduct that which was in excess of 5% of their total income. These changes in the federal tax code served as a way to "deal" with the increasing cost of health care by lessening the burden on the senior citizen, but it also reduced federal revenues. Thus it served to fuel spending and decrease revenues without impacting the way medical care was provided.

Health insurance legislation was not a big issue in 1951. A bill, the Emergency Professional Training Act, was introduced which would have provided federal funds for a wide range of activities including: scholarships to medical students, dental, and other health related students; federal payments to schools; and special training for practical nurses. The bill never passed because of opposition from Republicans concerned about costs, especially in the face of the Korean War.

From 1952 on it was clear that the medical profession, business, and the insurance industry represented a significant road block to national health insurance. Alternatives to universal coverage were sought that would cover some of the needy. Since the elderly's medical costs were quite high, there were inadequate health insurance programs available to cover them, and they represented a potent political force, a political solution was considered possible.

In 1953 Congress elevated the Federal Security Agency to Cabinet level and renamed it the Department of Health Education and Welfare(HEW). The PHS, still lead by the Surgeon General, was placed in the department, but PHS functions were not vested in the Secretary. Also a new position was created, the Special Assistant to the Secretary for Health and Medical Affairs, to be appointed by the president.

During Eisenhower's Presidential campaign he opposed compulsory health insurance because it represented "socialized medicine." Early in his Presidency, it was clear that there was inadequate health care coverage for Americans. To encourage the private sector to make health insurance cheaper and therefore cover more people, his administration proposed creating a federal reinsurance corporation that would protect health insurance companies against heavy losses. Although there was tentative support by some in the health insurance industry, the AMA was adamantly opposed to this saying it represented the initial inroads of socialized medicine. Organized labor also lobbied against the bill because even though the idea had merits, they felt the adoption of such a program would prevent the more needed program of national health insurance. In the end with the AMA's opposition, because the bill went too far, and labor's opposition, because it did not go far enough, the bill died in committee.

The health care costs to the individual citizen continued to increase. Congress once again enacted changes to the tax law so that individuals could deduct medical expenses above 3% (previously 5%) of total income and the maximum deduction was increased. Drugs and medications were added as deductible items for the first time.

In 1954, the federal spending on the Hill-Burton Program was increased and money was directed for special programs, i.e., diagnostic and treatment centers, chronic hospitals, rehabilitation facilities, nursing homes. This was the first time Congress had been so specific.

The 84th Congress (1955-56) passed the Poliomyelitis Vaccination Assistance Act of 1955, but not without significant controversy. The Democrats wanted to provide free polio vaccination to all but the administration preferred to base it on financial need. Eisenhower's Secretary of Health Education and Welfare(HEW), Oveta Culp Hobby, said the Democratic proposal was "socialized medicine by the back door." The AMA agreed with Hobby and strongly opposed free vaccination. A compromise was made and federal grants were given to the states so they could provide free vaccination to children and pregnant women. This was also the year the National Library of Medicine was created as a branch of the Library of Congress.

In 1956, the Health Amendments Act was passed. This bill authorized the Surgeon General to award traineeships to health profession students for graduate and specialized training in public health and medical administration. The 84th Congress also extended the Hill-Burton Act for two more years. All of these programs served to increase the federal funds spent on health

care, directed where the funding was to go, but the control was still in the hands of the medical profession.

Although national health insurance legislation was not considered, Congress did continue work on providing health care programs for special groups. In 1956 the Dependents Medical Care Act was enacted which required the armed forces to provide free medical care to dependents of members of the armed forces. The requirement was to provide direct medical care in military facilities or for DOD to contract for health insurance arrangements. The cost of the program was included the DOD budget. The original name for this program (now known as CHAMPUS) was Medicare. The 84th Congress also expanded the Social Security Act to provide disability insurance, another "social" insurance.

In 1957 a bill was introduced by Representative Forand, (Dem., RI) with the support of organized labor. The proposal was to raise the Old Age and Survivors Insurance (OASI) Program tax and use the additional money to pay up to 120 days of hospitalization for OASI beneficiaries. The bill generated significant interest but was never acted upon. Congress did pass a bill lessening the impact of rising health care costs on those individuals over 65 years old by increasing the allowable income tax deductions. In 1958 a bill was passed authorizing one million dollars per year as a subsidy to the 11 schools of public health. The Hill-Burton Program was also reviewed and its funding was extended to 1962.

The 86th Congress (1959-60) took its role as employer to heart and in 1959 passed the Federal Employees Health Benefits Act. This act established a prepaid voluntary health plan for the federal civilian workers and their dependents. The costs of the program were shared equally by the government and the federal employee.

In 1960 Rep Forand reintroduced his bill in the House and Senator John Kennedy (Dem., MA) introduced it in the Senate. Organized labor and liberal groups heavily supported the bill but the Eisenhower administration, AMA, Republicans, conservatives, and business leaders were all opposed. After significant and emotional debate, the House Ways and Means Committee voted to kill the proposal. The administration then presented its own more limited proposal, which offered federal matching grants to the states to assist in paying for specific medical costs. Included in this proposal was an option for the states to purchase health insurance for individuals. This proposal was also defeated. Finally a proposal similar to the administration's, but less expensive and without the insurance purchasing option, was included in the omnibus Social Security bill. This final amendment known as the Kerr-Mills bill significantly increased federal spending. In 1950 the amendments to the Social Security Act allowed for the federal government to reimburse the state \$30 for the first \$50 the state had spent. In 1958 this changed to \$41.50 or \$46.75 of the first \$65 depending on the finances of the state. The Kerr-Mills bill increased this spending even more, because it retained the federal funding level for the first \$65 and then it added .

reimbursement to the state for 50-80% of the next \$12 per month for all beneficiaries.

The Kerr-Mills bill also created a new category of aid for those not poor enough for Old-Age Assistance but too poor to pay for all their medical costs. In this program, Medical Assistance to the Aged, the federal government paid for 50-80% of state spending.

The impact of these programs was tremendous. The implied federal policy was that the states would provide the spending controls since there were minimal restrictions placed on the federal funds. This "implied" policy never became state policy because it was difficult for the states to try to limit their spending since the program actually rewarded those who spent the most. For every dollar a state spent, it got 2 or three from the federal government.

That same year the 86th Congress made the 1 million per year subsidy to public health schools permanent. The program was also increased by an additional 2 million for project and institutional research grants.

On Jan. 9, 1961, prior to President-elect Kennedy's inauguration, the first White House Conference on Aging met. Although there was significant discussion, the final recommendations of the committee included amending the Social Security Act to provide medical care for the aged. That recommendation came as a surprise because President Eisenhower had organized the conference. Eisenhower's former HEW Secretary spoke to the committee and openly supported medical aid under SSA. Prior to the meeting, some individuals were concerned the AMA had manipulated the conferees to insure the outcome would oppose using social security to cover health care for the aged. During the meeting George Meaney of the AFL-CIO openly criticized the AMA for its negative position. The final vote by the committee was 170-99 to amend the SSA. The Health and Medical Care Section of the Committee, led by the President elect of the AMA, included in its statement that health care under SSA is unnecessary and undesirable, but these comments were stricken from the final conference recommendations.

Following the conference President Kennedy submitted his proposal to provide compulsory federal health insurance for the aged through the Social Security program. The administration's proposal was to be financed by an increase in the payroll tax on both employers and employees. Benefits were to include up to 90 days of hospital care, 180 days of skilled nursing service, plus certain diagnostic and home health services. With a Democrat in the White House and a majority in both the Senate and House, passage by party line alone would have been simple. The problem was there was no unity in the Democratic party. The ranking members of the Senate Finance Committee and of the House Ways and Means Committee, both opposed the Kennedy administration's proposal. The bill has defeated by a coalition of Republicans and southern Democrats.

Although no health insurance bill passed, federal spending on health care continued to climb. The Kerr-Mills matching formula was increased, IRS deductions for medical expenses were

increased, the Hill-Burton Plan was increased and extended until 1963, and the Community Health Services and Facilities Act passed which increased grants to the states to 50 million dollars from what had been 8 million in 1935.

In 1963 President Kennedy resubmitted his proposals. The bill was passed in the Senate, but the outcome was far different in the House. The Ways and Means Committee stripped the health care provisions from the administration's bill. When the House-Senate Conference Committee was unable to overcome these differences, the whole bill died.

Although the health insurance proposal for the aged died, Congress and the administration authorized a rapid increase in health spending. In 1964, Congress passed the mental health facilities bill that encouraged construction of facilities for the mentally retarded, community mental health centers, and funded training to teachers of the mentally retarded and handicapped children. The Health Professions Medical Assistance Act was passed which provided money to construct and rehabilitate health profession schools. The bill also provided a program of loans for students of medicine, dental, and osteopathy. Optometry student aid was approved for the first time. The Nurse Training Act was passed which served to expand nurse training programs and provide student loans. The 1956 Health Amendments Act that dealt with Public Health training was extended. The tax code was amended to allow persons over 65 unlimited deductions for medical expenses. The Hill-Burton Act was extended for 5 more years. All of these programs continued to increase the reliance of American health care on the federal dollar.

After President Kennedy's death, President Johnson directed changes in health care policy that tremendously increased federal spending but in addition, marked a change in role for the federal government. Prior to his administration, the federal role had been to encourage the development of medical facilities, practitioners, and research. Now the government was beginning to move into the provision of direct health care for many Americans. President Johnson stated that great technical advances in health care had been made but he was concerned about the improving the "availability and access" for all Americans.

The 1964 Congressional elections significantly changed Congress. Not only was there now a two thirds majority of Democrats in the House but the increase had come predominantly from the North. The southern Democrats and the Republicans could no longer present a block. The House Committee on Ways and Means, for the first time ever, reported positively on a federal health insurance program for the aged. Although the Senate had only two more Democrats than before, the popular support shown for Medicare in the general election had increased Senate support for the proposal.

Although Congress had changed, the AMA had not. There was still tremendous fear that this would lead to government interference with the practice of medicine. To reduce the AMA's opposition, based on the concern for "socialized medicine," the administration's proposal included only a hospital benefit and did not cover doctor's fees. The AMA recognized there was large

scale public support for Medicare. In its effort to defeat the bill, the AMA offered a voluntary program of insurance that would cover both hospital and doctor costs, called "Eldercare." It was hoped that pointing out the deficiency of Medicare would undermine support for the bill. This counter proposal had a completely unintended effect. Since the campaign by the AMA clearly communicated to the public that doctors fees were not included in the administration's proposal, rather than serving to defeat Medicare, the supplemental coverage of doctor fees in "eldercare" was incorporated into the compulsory program. When passage of the bill appeared likely, many physicians threatened a boycott. The AMA legal counsel informed the members that this would likely be viewed as an antitrust violation. In October, three months after the bill was signed, the AMA House of Delegates adopted a resolution that effectively ended the threat of a doctor strike.

Medicaid was included with Medicare, although it did not reflect a significant change in national health policy, since it was simply an increase in the existing 1950 Kerr-Mills program.

The 89th Congress and President Johnson's' impact on health care did not end with Medicare and Medicaid. Many bills dealing with health care were passed. The Heart Disease, Cancer, and Stroke Amendments of 1965 composed a three year program of 340 million dollars in local grants to encourage planning and establish regional medical programs to deal with these specific problems. The AMA initially opposed these programs but Johnson directed the Secretary of HEW to work with the AMA to lessen their objections by insuring physicians had leadership roles.

Congress increased and extended the Community Mental Health Center Act, which provided 224 million dollars in grants to both public and private organizations, to pay initial costs of technical and professional personnel at community mental health centers. It also included money for research programs to improve educational opportunities for handicapped children and continued to support the training of teachers for the mentally retarded and handicapped children.

The Community Health Service program was extended and four existing programs were increased: 1) grants for immunization s, 2) migratory worker's health services, 3) public health grants, and 4) community health services.

The Health Research Facilities Amendments of 1965 extended and increased grants for the construction of health research facilities and authorized the PHS to enter into research contracts. This act also authorized the Secretary of HEW to appoint a total of six Assistant Secretaries.

The Health Professions Assistance Act allowed for increased student scholarships and loans to health professions students. It also increased funding for construction and improvement of health profession educational facilities.

1965 was also the first year of the Cigarette Labeling and Advertising Act requiring "Caution: Cigarette Smoking May Be Hazardous to Your Health," to be printed on the cigarette package.

The problem with all of this legislation lay not with the purpose, but with the lack of integration. These programs fueled a tremendous growth in facilities, providers, and services, with sometimes redundant or conflicting service. All of this had been completed without coordinated federal or regional planning. The implied federal policy was simply, more is better. Although the professional organizations had lost in opposing compulsory health insurance, the individual provider had not surrendered any control. Unfortunately what had been created was a health care system with no central organization and tremendous dependency on the federal dollar.

It became clear to the Johnson administration that in order to provide access to care and to prevent duplication of services, there was a need to coordinate health services at the regional and state level. The Comprehensive Health Planning and Public Health Services Amendments were enacted by the 89th Congress(1965-66) to assure quality health care was available to all Americans, with the proviso that the bill would not interfere with existing patterns of private practice. The program provided funds to set up state and regional authorities to coordinate and plan health services and encourage the participation of public and private health care organizations. It also authorized funds for state health authorities to provide direct public health services. It encouraged interchange between state and federal health personnel and it also authorized grants to public health schools for technical assistance to state or regional programs for public health planning.

The 89th Congress also passed an aid program for both allied health personnel and health professionals. The bill was designed to increase the numbers of allied health professionals and improve their training by a program of grants for the development and improvement of curriculums and for the construction and rehabilitation of schools. The bill also revised the loan program to health professionals so that individuals could have 15% of their loan forgiven for each year they practiced in an under-served area. The bill continued the program of direct federal loans to students and also initiated a government funded program of loans that was administered by the schools. This had originally been proposed to be a government subsidized and guaranteed program of loans from private organizations, i.e., banks, but this aspect was eliminated before passage.

President Johnson was the first President to express significant interest in birth control. In 1966 several items were enacted that increased the government role in family planning services. This action included funding health centers and programs that would provide contraceptive counseling along with primary health care.

In 1966, HEW was given full control of the PHS. The Secretary then delegated PHS functions to the Surgeon General. The PHS was reorganized into five divisions:

- 1) Bureau of Health Manpower
- 2) Bureau of Health services
- 3) Bureau of Disease Prevention and Environmental Control

- 4) National Institute of Health
- 5) National Institute of Mental Health

In 1967, planning for health care services again took on added importance. The Partnership for Health Amendments of 1967 extended the Comprehensive Health Planning and Public Health Services Amendments of 1966 and significantly increased the funding levels. This program provided grants for regional health services, state and area wide planning, and research grants to schools of public health. These acts highlighted the fact that the federal role still was not to mandate health services but to provide funds to encourage regional health planning. These were still evolutionary steps since, in the past, planning had been left completely to the medical profession.

A special advisory committee to President Johnson, The National Advisory Commission on Health Manpower, reported in 1967 that the country was in a health crisis. The commission concluded that while the cost of medical care was rapidly escalating, the quality was not increasing proportionally. The commission further stated that although more health professionals were needed, the situation would not be resolved by simply generating more. Reforms involving physicians, hospitals, medical schools, and insurance companies would be needed to resolve the crisis. The commission further concluded the crisis was brought about by the medical professions lack of leadership and its unwillingness to change. The commission noted that the average cost for a day of hospitalization was \$45 in 1966, up 300% since 1950. It was predicted that if nothing were done, the costs of medical care would go up 170% over the next five years. The committee specifically recommended:

- 1) Medicare and Medicaid should institute payment systems that foster efficiency and quality
- 2) Medical providers need to have their skill periodically reassessed.
- 3) Peer review of medical care should be performed at the local level for doctors, hospitals, and insurance companies.
- 4) Direct federal loans should be made available to medical and dental students and residents. Pay back options should be repayment over a long term or national service.

In 1967 the PHS was reorganized and the Health Services and Mental Health Administration was added. The Surgeon General no longer reported directly to the Secretary but now was subordinate to the Assistant Secretary for Health.

The 90th Congress(1967-68) extended the Hill-Burton program for two more years. There had been attempts to modify the program from its original intent to fund predominantly rural hospitals, so that it would now provide funds for urban hospitals, but these changes were not implemented. This Congress did pass the Health Manpower Act that increased the funding for construction, improvement, and scholarship for several health professions training program.

During Johnson's tenure as president, there was a tremendous increase in spending but also a growing awareness of persistent problems with American health care. Early in the Nixon Presidency, he announced that he, like Johnson, wanted to improve

the quality of American medicine and make it more fairly available, but he stated we cannot simply buy better medicine, it needs to be more efficiently organized. The Nixon administration felt the problem was the federal role had grown too large and he wanted to reduce federal responsibility. The Democrats controlled the 91st Congress and they did not share the Nixon vision. Initially the administration was slow to develop health proposals and little was accomplished in 1969. In 1970, the Hill-Burton program was due to expire. Nixon wanted to eliminate the program and institute a system of block grants and direct loans to support hospitals. Congress, instead, actually increased the appropriation and extended the Hill-Burton program. Nixon vetoed this but Congress easily overcame the veto.

This pattern occurred over many other health programs, President Nixon would request cutbacks and revisions in programs and the 92nd Congress would extend and increase existing programs.

Recognizing a shortage of doctors in general practice, Congress passed a bill authorizing grants to hospitals and medical schools for the development of family medicine teaching programs. Nixon vetoed the bill because "it continues the traditional approach of adding more programs to the almost unmanageable current structure of federal government health efforts." He felt other programs, already in existence, could achieve the same effect. Congress was unable to overturn this veto because Nixon used a "pocket veto," meaning he vetoed the bill during a Congressional recess and Congress was not able to meet in time to overturn the veto.

In 1971 Senator Edward Kennedy(Dem., MA) and Rep. Martha Griffiths (Dem., MI) introduced a proposal for national health insurance. Their plan provided universal health insurance administered by the federal government and financed by a combination of payroll taxes and general revenues. Their plan was to cover all citizens without regard to age or income.

The Nixon administration countered by proposing to require employers to develop a comprehensive health insurance program and to replace Medicaid with a broad government insurance system that would replace the federal matching grants to the states with an all federally funded program. This proposal included a sliding scale payment mechanism based on income.

The AMA proposed its own plan, with a sliding scale tax credit for purchasing private health insurance, and then federally subsidized health insurance to low income people.

Even the Health Insurance Association of America proposed a plan where federal standards would be developed and then private insurance companies would provide the coverage. Their plan would be funded by an employer/employee payroll tax and government subsidized state-sponsored insurance would be available for the poor.

No longer was it claimed that these proposals represented socialized medicine. This was due to the tremendous increase in the cost of medicine and it's burden on the national economy. Medical costs had gone from 4.6% of the GNP in 1950 to 7.1% in 1970, and it was expected to continue to increase. Discussions

highlighted the rapid increase in the number of physicians, pointing out that many of the new physicians were not engaged in direct care but instead in research and administration. There was recognition of a maldistribution of resources and a tremendous variability in medical services available from one locale to another. Although 85% of the citizens under age 65 had medical insurance, the coverage was primarily for surgery and hospital care. There was minimal coverage of outpatient services. The existing insurance coverage encouraged the use of expensive inpatient hospital care when ambulatory care would be more economical.

Although all sides now stressed the need for health insurance coverage, the final outcome was still the same; no insurance proposal was reported out of committee.

In August of 1971, in an attempt to deal with inflation, President Nixon implemented a mandatory general wage and price freeze. This program was later modified by lifting the general freeze and dealing with health care costs by limiting the rate of increase in both hospital charges and doctor fees.

In 1972 the National Health Service Corps was developed to meet more of the health care needs in under-served areas, both rural and urban. The program offered loans during medical school that were paid off by service.

Nixon used his veto power when Congress appropriated 1 billion dollars more for HEW than he requested. His final veto left the Department running under a continuing resolution.

In an attempt to institute more control of health care at the local level, Congress approved a medical peer review system, known as Professional Standards Review Organizations (PSROs). This program required the formation of local physician groups that would review the appropriateness of medical care for those patients covered by Medicare and Medicaid.

In 1973 President Nixon announced his intentions "to safeguard the country's pluralistic health care system and to build on its strengths, minimizing reliance on government-run arrangements." His goal was to reduce federal spending on health and eliminate the direct care programs. The Democratic controlled Congress fiercely resisted all efforts to change and simply extended the existing programs. National health insurance sparked debate but it once again never made it out of committee. Both Congress and the President recognized the problems of overspending on health and the maldistribution of resources, but they could not agree on how to deal with the problem.

An administration proposal was passed giving federal support to aid the development of Health Maintenance Organizations (HMOs). The AMA was opposed to this legislation saying that HMOs would interfere with the individual practice of medicine, but the AMA was no longer as effective in lobbying as in the past. Sen. Kennedy wanted to amend the bill to include more money to care for those with poor health but this change did not make it to the Senate Floor. What passed, encouraged the development of programs that were predominantly for the healthy. Today, one of the problems of HMOs is that they are "risk adverse." This was designed into the original legislation.

The Emergency Medical Services Act was enacted, authorizing grants for planning, establishing, and operating area wide systems of emergency medical care. It also authorized money for training and research in emergency medical care.

This same year, The Supreme court set guidelines that limited states in their attempts to regulate abortion during the first three months of pregnancy.

In 1974, the Health Planning System was created to insure the federal dollar was being spent where it was needed. This program set up a national network of local health systems agencies(HSAs) that would provide health planning. The program combined the Hill-Burton program with two other federal funding programs. The hope was this program would eliminate redundancies and improve access to health care. The power behind the bill was that HEW could withhold funds to facilities that did not comply with the HSAs recommendations.

The Nixon administration's health care proposal in 1974 included:

- 1) Employers would be required to offer plans with a standardized benefit to their employees.
- 2) There would be federally subsidized care to the poor.
- 3) Medicare would be restructured.

President Nixon pledged that health insurance was his top domestic priority. The opportunity for passage of health insurance legislation again looked very good. Senator Edward Kennedy (Dem., MA) modified his previous proposal and worked with Representative Wilbur Mills (Dem., AR). A compromise bill was submitted that allowed for a large role by private insurers and required the individual to pay for a share of their coverage. The Kennedy-Mills proposal relied on a payroll tax for financing while the administration wanted a voluntary program paid for with private premiums. Kennedy-Mills proposed a large plan administered by the federal government while the administration wanted more state and private involvement. The differences were never worked out because American labor resisted the compromises that had been included in the Kennedy-Mills plan. Labor insisted on a compulsory insurance plan without deductibles or co-payments. They again lobbied that no bill was better than an inadequate bill. Then HEW Secretary, Casper Weinberger publicly condemned labor's stance.

The timing for the completion of hearings on the bill was also poor, as it coincided with the Nixon impeachment hearings. The issue was not reported out of committee. After Nixon's resignation on Aug. 8, 1974, members of congress and President Ford stated they wanted to have a good health bill. A compromise bill was drafted with a mandatory insurance coverage financed by private insurance premiums. The House Ways and Means Committee argued over the compulsory coverage and the financing methods. The final vote by the committee, approved the bill on a 12-11 vote but the Chairman did not refer the bill to the floor because of the narrow support.

In 1974, medical cost controls ended for the first time since 1971. Most other cost controls had ended in 1973 but they had been selectively continued for health care. The

administrations had actually requested to temporarily extend cost controls, but the request was tabled in committee and the authorization expired.

Legislation enabling the health manpower authorizations was also expiring. Changes were proposed to deal with the maldistribution of physicians, the shortage of primary care physicians, and the country's increased reliance on foreign medical graduates. The bill to reform and extend these funds also died in conference.

Abortion was continuing to gain attention as a national issue. In 1974 there were attempts to prevent federal funding of abortions but they were never passed.

The Employee Retirement Income and Security Act (ERISA) was passed enabling large companies to self-insure their workers. The law specifically exempts those companies from state regulations. This bill has had a tremendous impact on states' ability to supervise the health insurance benefit of their citizens. Since this federal law specifically pre-empts state law, the bill completely blocks states from regulating the health care package provided by ERISA protected employers.

In the 94th Congress (1975-76), the Democrats had further increased their majority and there were many new liberal House members. Speaker of the House Carl Albert announced that NHI would be one of the first bills considered. Even the AMA had further softened its position and was offering a plan that required employers to provide insurance for their employees. The biggest question remained is where should the funding come from, the private sector or federally financed through income or payroll taxes? At first it looked as though NHI could be easily passed, but there were several factors that were weighing in against it. The most important was the recession was beginning to take its toll. Even though President Ford had been supportive of a national health plan in the past, he was now much more concerned about finances and he announced he would not sign any legislation that would increase spending. He did say he would support such legislation in the future when the economy improved. The Democrat controlled Congress could have overcome a presidential veto, but a procedural conflict between two House committees, Ways and Means versus Interstate and Foreign Commerce, prevented legislation from being written. Both committees claimed jurisdiction. Other factors against the bill were an increasing anti-Washington sentiment, coupled with widespread concern, that given the existing federal bureaucracy, another massive program would not be wise. The combined effect of all of this was that national health insurance went from hot legislation, to at best, on hold.

During the congressional hearings that were held, health care costs were noted to have doubled between 1970 to 1975 and quadrupled since 1960. In spite of this, there were still tremendous problems such as provider maldistribution, under-service, and 22 million Americans were uninsured. Reasons attributed to these problems were inflation, the rapid increase in technical advances, and the lack of competition.

The 94th Congress was also busy with other health care legislation. President Ford proposed consolidating many of the federal health care expenditures in a program of block grants to the states. The administration stated this would allow the states greater flexibility in dealing with multiple federal programs. The flexibility would not have come unencumbered as President Ford also proposed huge spending cuts. Congress did not accept the President's proposals and extended the programs, even overcoming presidential vetoes.

Medical groups challenged the 1972 peer review organizations (Professional Standards Review Organizations), but the Supreme Court rejected the arguments saying the program was constitutional.

The Federal Trade Commission(FTC) and The Justice Department began a program of close review of the AMA and the medical field to insure medical providers were not inhibiting competition unfairly. Specifically, FTC and Justice looked at the impact of the medical profession's ban on advertising and to see if the AMA was restraining the supply of doctors.

In 1976 a health manpower bill was designed with the intention of easing the maldistribution of physicians. Statistics were cited showing a surplus of surgeons and specialists and increasing numbers of foreign trained physicians. The original proposals included: 1) giving medical schools quotas to insure graduates went to practice in under-served areas, 2) requiring all medical students to practice for four years in an under-served area or pay back the federal capitation support they had received during medical school, 3) setting up a national council that would set the number of residency positions to limit specialty and encourage primary care training, and 4) limiting the training available for foreign medical graduates(FMGs). The AMA and medical schools opposed these proposals saying they would have unfairly targeted the medical profession and the greatest impact would be on the low income student. The legislation finally enacted, included a soft provision encouraging medical schools to voluntarily meet a quota of graduating students in primary care, an increase in the federally guaranteed loan programs, an increase in the NHSC scholarship program, and funds were extended to other health profession programs. The bill dealt with FMGs by taking away the US immigration preferences for those that had not passed qualifying exams and denying visas unless they had been accepted in a medical school or residency, possessed basic English skills, and promised to leave after their training program. President Ford signed the bill but expressed concern about the increased spending that it contained.

The 94th Congress also extended support for the Health Services and Nurse Training bill. President Ford had pocket vetoed the bill during the previous congressional session because he believed federal support should be decreased and other funding sources found. He had proposed ending formula grants to the states and phasing out support for community mental health centers. During this session, without President Ford being able to use the same technique, Congress easily overcame his veto. The programs included in the bill were family planning, community

mental health centers, migrant health care, health centers for the poor, nurse training, and state formula grants for health services.

Congress also passed an extension of support for the National Health Service Corps that permitted the Public Health Service to assign doctors to serve in under-served areas. Ford vetoed this bill but again, congress overwhelmingly overturned it.

A federal program dealing with medical malpractice insurance was considered but the general consensus was that states should handle the problem. Unfortunately, even though 30 states enacted legislation, their action did little to control the rising costs.

The 1973 legislation, encouraging the development of HMOs, was amended to ease some of the restrictions. The original requirements had made the set up costs quite high before HMOs could be eligible for grant money.

In the second session of the 94th Congress, little happened with national health insurance. The jurisdictional issues between Ways and Means and Commerce had not been resolved, President Ford had reaffirmed his objection to a comprehensive program, and 1976 was an election year.

After the election, President-elect Carter intended to have a comprehensive national health insurance program that would be implemented in stages. He wanted a catastrophic plan as the first stage of NHI but conservatives saw this as a "foot in the door" and liberals were again afraid it would prevent comprehensive legislation from being enacted.

Rampant inflation and the recession quickly altered President Carter's implementation schedule. There was widespread recognition that health care inflation was out of control. President Carter wanted to defer his interest in health insurance until costs could be brought under control. There was considerable debate about what this control would entail. It was apparent that the normal market forces did not seem to be working. Facilities and providers were definitely increasing, so theoretically, the demand for services should decrease. Instead, the demand for health care services was increasing. There was concern that NHI would only fuel the fire. Conservatives felt that the health care problem did not represent a market failure, but that federal legislation and health policy were preventing the market from correcting. They felt by manipulating the tax code and providing vouchers to the poor, the private sector could solve the problem. The Carter administration disagreed and targeted hospitals as the major source of the inflation saying hospitals represented 2/5ths of the total health care costs. Outpatient health care was not targeted because the administration thought more was needed to decrease the reliance on hospitals. The administration wanted to limit growth in hospital reimbursement and limit construction by placing cost controls on hospitals. Carter's hospital cost control plan was very complex. The proposal was opposed by the AMA and the American Hospital Association who felt that the cost cap would decrease the quality of care. Congress never accepted the President's proposals

In 1978 the administration's push for hospital cost control began again. After much debate, the House Commerce Committee would only support a resolution that endorsed hospitals voluntarily attempting to control costs. At the other end of the Capital, the Senate Finance Committee approved a bill that offered a prospective payment system based on the hospitals historical record of charges. After significant debate, this passed the Senate, but it was never acted on in the House.

The 95th Congress did little to limit spending on existing health care programs. Most of the programs that came up for review were extended. Medicare/Medicaid fraud and abuse was recognized as costing tremendous amounts and a bill was passed increasing the penalties and encouraging increased policing.

Congress did enact a bill to encourage Rural Health Clinics. The bill extended Medicaid and Medicare reimbursement to include physician assistants and nurse practitioners and provided pilot programs for establishing or keeping rural clinics.

President Carter was still concerned about the high costs of health but he was being pressured to begin his staged program of national health insurance. Sen. Edward Kennedy (Dem., MA) offered a more aggressive plan and this caused significant controversy in the Democratic Party. No NHI bills were enacted.

The administration saw HMOs as a positive alternative to fee for service medical care. HMOs were appreciated not only because of their cost savings but because they aligned with the President's philosophy of offering more outpatient care and reducing the need for hospital services. Congress passed legislation that extended the original 1973 legislation and authorized additional grants and procedures to encourage the acceleration of their development.

President Carter vetoed a nurse training bill, saying it had gone on long enough and now there was no longer a shortage.

In 1979 the Health Planning Act was extended requiring the regional planning for health care. The administration and congress hoped this would lead to stabilizing the prices by extending the prior plan.

The Carter administration again reinitiated its push for hospital cost controls. The new proposals would regulate hospital revenues only if hospitals failed to voluntarily reach spending limits. The plan included a very complicated formula that, to ease objections, excluded 57% of hospitals from cost control. The proposal was soundly defeated in the House. It was also killed in the Senate, but a bill was introduced that would limit payments to hospitals for Medicaid and Medicare patients. This never was voted on or referred to the House.

The nurse training bill, that had been vetoed during the last session, came back up for action. Against the administration's recommendation, the funding was extended, although at half the strength.

President Carter decided that 1979 was the time to introduce his health insurance proposal for a mandatory catastrophic insurance plan for workers. He commented that thirty years of work towards national health insurance had been blocked because of the all or nothing approach taken by its supporters. There

seemed to be support for the bill in both parties but labor was still lobbying against the proposal, because it did not provide coverage for the poor or those with inadequate coverage. The Senate Finance Committee had shaped a proposal that would set the deductible at \$3,500 and employers would be required to cover their employees. Before the committee voted on the proposal, the administration and some committee members changed their approach to the bill and wanted to add more benefits for the poor. There was no time to work out a compromise before the end of the session and the bill died.

During the 1980 election year, Congress was heavily involved with budget cutting. National health insurance was not on the agenda. Medicare and Medicaid were revised authorizing some modest changes. Cost savings were added but more services and more beneficiaries were covered. A provision to reimburse hospitals based on nationally averaged fees was proposed, but removed from the final bill.

A new federal program was enacted that voluntarily certified the private Medicare supplemental insurance policies known as Medigap. This served to set a standard benefit for this type of insurance. These insurance policies tend to decrease the impact of co-pays and deductibles and potentially increase the demand for services.

In 1979 the Mental Health Systems Act was passed increasing federal funds for mental health services. The bill extended the Community Mental Health Centers Act and also provided additional services for the elderly, children, and adolescents.

Congress introduced, but failed to enact, a medical records privacy bill that would have permitted patients the right to correct medical information and establish federal rules on medical privacy. The bill was defeated because of the inability to satisfy the conflicting needs of civil libertarians, psychiatrists, and law enforcement personnel.

When President Reagan took office in 1981, medical inflation was 12.5%; the highest it had ever been; 2.4% above overall inflation. The intentions of the Reagan administration were clear, ramp back federal support to most programs and turn back the responsibility for these programs to the states. Federal entitlements were seen as the cause of the economic crisis and the only way to solve this was by decreasing the federal role. The administration proposed to deal with health care spending by providing block grants to the states, capping and reducing the federal funding, ending subsidies for HMOs, and eliminating subsidies for training health professionals.

The 97th Congress(1981-82) had a Republican majority in the Senate and a Democratic majority in the House. The administration plan called for the consolidation of 25 health programs into two block grants, and then reduce the federal funding to these programs by 25%. Congress instead, included 19 of the programs in 4 block grants and the others were left under federal control. The congressional cuts were not as deep as the administration wanted. Congress agreed to cut Medicaid by one billion dollars a year but rejected the idea of a ceiling. The

cuts were to be achieved by reducing the federal share paid to the states.

C. Everett Koop was nominated by Reagan to be Surgeon General. Koop was known for his strong antiabortion writings and it was a long and difficult nomination process. Existing law required that the Surgeon General come from the ranks of the PHS and that he or she must not be over 64. Koop failed on both of those criteria so President Reagan had to request that the law be changed. Koop promised not to use the Surgeon Generals Office to promote his antiabortion stance and during his tenure he kept his word, to the displeasure of antiabortion forces.

The Reagan administration was consistent in the desire to reduce the size of the federal government, even when it came to planning. Many of the programs that had been previously enacted to try to reduce spending were intended to be cut. The administration proposed to eliminate the funding for PSROs and replace them with local review boards. They wanted to phase out the federal funding for the health planning system. Congress did not eliminate either program but did agree to reduce funding. The proposal to reduce spending for health care professional training was also heeded by Congress but not cut as low as Reagan desired. The same thing happened with HMO support. Even though the administration was supportive of HMOs, they did not feel it was appropriate to continue to provided federal support. Congress instead continued the funding but at reduced levels.

The administration wanted to completely disband the NHSC but the House wanted to retain it. The Senate agreed with Reagan but support for the NHSC was restored in conference.

Even though the administration disagreed with some of the above legislation, Reagan signed it because it was presented to him in a consolidated bill, the Omnibus Budget Reconciliation Act of 1981. By combining several programs in one bill, it made it impossible for the President to veto one program without jeopardizing all the programs. Despite the many cuts that had been enacted, health spending continued to rise.

In the face of continued health care inflation and a rapidly increasing federal deficit, 1982 brought a second round of Medicare and Medicaid cuts. One proposal to deal with the increasing costs was to place a ceiling on payments to doctors and hospitals. After heated debate, actual ceilings were not implemented, but payment restrictions were placed on hospital reimbursements. Concern was expressed that these steps would encourage cost shifting to other payers and not actually improve health care financing.

The AMA was concerned about scrutiny by the FTC and requested an exception to FTC rules for physicians and other health professionals. The AMA felt the antitrust laws prevented doctors and hospitals from working together to be more efficient. The FTC was concerned working together would be too easily just another name for monopoly. The FTC won the argument.

In 1983, health care costs were still rising. This time Congress enacted revisions to Medicare that put in place a prospective payment system utilizing Diagnosis Related Groups (DRGs). With DRGs, the rates for hospital services are set

in advance, based on the hospitals historical costs and the diagnosis of the patient.

The 98th Congress considered a program of health insurance for the jobless. It was proposed to provide insurance coverage for those individuals and their families when they were between jobs. Unemployment at the time was higher than it had been in 41 years. The full House of Representatives approved the plan as did the Senate Labor and Human Resources Committee but the bill never came to the floor of the Senate. President Reagan did not support the legislation but had said he would sign it if it could be offered in a budget neutral manner. This prevented any clear way to finance the bill. Some liberals were concerned the bill did not do enough, moderates were concerned about adding a new program in the face of cutting back on Medicaid and Medicare, and conservatives did not want to offer a new program that would increase the federal deficit.

Reagan again opposed the continuation of the health planning system but congress continued it anyway.

With health care costs continuing to rise, Congress ordered a temporary payment freeze on physicians hoping to save some money.

With the increasing costs of health care, quality was still a question. Infant mortality in the US was higher than in most other developed countries. Congress enacted legislation requiring states to broaden Medicaid coverage to include more low income pregnant women and children, hoping to decrease infant mortality.

In 1985 Congress did not deal with NHI but did enact legislation requiring employers of over twenty employees to allow their employees to voluntarily stay enrolled in the company's group health plan for up to 18 months after employment ended. The employee had to pay for the coverage at the cost of no more than 102% of the employers cost for the coverage.

In 1985 President Reagan vetoed funding for the National Institutes of Health but Congress overcame the veto. He was able to pocket veto a bill setting up a national advisory council on health promotion and disease prevention.

He signed the nursing education bill after originally saying he would not support it because the program had outlived its usefulness. He also signed legislation continuing aid to medical schools and their students. He had vetoed the same legislation in the previous congressional session.

In 1986 Congress originally introduced legislation in both houses to extend the NHSC scholarships but the bill died in committee. The 99th Congress(1985-86) dealt with nine different health programs by grouping them in another Omnibus Health bill. The bill:

- 1) set up a no fault compensation system for families of children injured by vaccines.
- 2) Set up the computerized national data system on doctors with malpractice records. The concept was that tracking incompetent physicians would decrease the cost of health care due to malpractice.

- 3) required states to create plans to deal with the needs of the mentally ill.
- 4) funded research into Alzheimer's Disease.
- 5) set up a national commission on infant mortality.
- 6) allowed the export of drugs not yet approved for use in the US.
- 7) funded the establishment of geriatric care training programs.
- 8) repealed the health planning legislation that had originally set up the Health Systems Agencies.
- 9) Phased out federal support for HMOs.

In 1986, the Budget Reconciliation bill was passed six months late. Medicare had grown by 11% in 1986 and many steps were taken to try to bring cost under control. Congress chose to slow the implementation of the prospective payment system by one more year. Testimony showed DRGs were saving some money but critics said this was being accomplished by discharging patients "quicker and sicker." There was no data to support a decline in quality of care but the tools to measure quality were quite limited.

To lessen the impact of the prospective payment system on hospitals serving large numbers of poor individuals, an additional reimbursement was created. These hospitals were termed Disproportionate Share Hospitals (DSHs). The same legislation also covered areas to save money. The bill extended the freeze on doctor fees that had been in place since July 1984. An exception was implemented for doctors who would take assignment, meaning they would not bill above the Medicare allowed rate. Physicians accepting assignment would receive a 1% raise on top of the increase for inflation. To save money on payments to hospitals, the anticipated increase in payments to hospitals was cut in half. Reimbursement to training hospitals was also decreased.

In 1987 Democrats took control of both the House and Senate. They were able to pass another omnibus health bill that included reauthorizing funding for the NHSC and the federal childhood immunization program.

In 1988 Congress once again approved an omnibus health bill that included the first federal policy program to deal with AIDS. It also included continuing the funding for health manpower training, prevention and health promotion, health Professions training, and nursing education assistance. The omnibus bill made it once again impossible for the President to veto just one of the programs.

Congress continued to try to decrease the outlay of expenditures in the Medicare program by many complex manipulations of the reimbursement for hospitals. Exemptions were made for rural hospitals and for disproportionate share hospitals, but most facilities had their increases due to inflation limited.

Because of concern about poor standards in nursing homes, Congress prepared new standards for programs that participated in care to Medicare and Medicaid beneficiaries. Although the

standards were set by the federal government, the compliance was to be reviewed by the states.

In 1988 the Senate Labor and Human Resources Committee approved a bill that would require all employers to provide health insurance for their workers. It was estimated there were 37 million uninsured individuals in the US. The bill was introduced by Senator Kennedy and strongly opposed by the administration because it would have increased federal spending. Even though leading Republican critics stated the bill was well intentioned and dealt with an important issue, it did not make it to the floor of the Senate or the House.

A unique congressional event was the passage, and then the later repeal, of the 1988 amendments to Medicare dealing with catastrophic health insurance, the Medicare Catastrophic Coverage Act. During President Reagan's 1986 State of the Union Address, he had called for the development of a catastrophic insurance program. Reagan requested his Secretary of Health and Human Services, Otis Bowen, develop a legislative proposal. At the end of 1986 Bowen recommended expanding Medicare to provide catastrophic coverage for its beneficiaries. Congress worked on the plan for a year and a half before passing the legislation. The final bill capped Medicare beneficiaries' outlay for medical expenses at \$2000. Other provisions included were a new benefit for prescription drugs, respite care, and increased home health care. To finance this expansion, the program increased the Medicare beneficiaries basic premium and also added a supplemental premium based on the income of the beneficiary. This would have tremendously increased the outlay of funds through the Medicare program but the financing would have been born by increased contributions from senior citizens alone. The program did not provide coverage for long term care. Even though it had been greatly expanded from his original proposal, President Reagan signed the bill saying it would remove a tremendous burden from America's senior citizens.

Between the 100th and the 101st Congress, senior citizens had strongly protested that they were being made to pay the entire cost of the new program. Since they were the intended beneficiaries of the act, the landslide of public opinion against it caused the 101st Congress to reconsider. The majority of senior citizens did not feel that they were individually likely to benefit from the program and therefore did not wish to pay for the benefit. Wealthy senior citizens, who were least concerned about the cost of health care, were charged the most for the insurance and thus they protested the hardest and probably most effectively. Early in the new Congressional term, the bill was repealed.

In 1989 Congress completely overhauled the Medicare physician payment program. A nationwide fee schedule was designed based on the relative value of medical services. This was implemented to correct the problem that surgical and procedural services were excessively reimbursed while primary care services were underpaid. The new plan also limited the amount doctors could bill their patients above the Medicare acceptable fees. Additionally, a safety valve was added that

would allow the government to save money if providers tried to make up for the decreased fees by simply increasing the volume of services they provided. Another provision prohibited referrals to services owned by the provider or his or her family. Finally, reimbursement was frozen at prior levels.

The plan to save money on Medicare also reduced payments to hospitals but it continued to come up with a wide number of exemptions and increased payments for hospices and various rural, disproportionate share, and cancer hospitals.

In 1990, Medicare payments to doctors and hospitals were again reduced. Medicare costs to beneficiaries were also raised. Tremendous numbers of detailed regulations covering Medicare and Medicaid were enacted. In spite of the escalating costs of health care, Congress continued to expand reimbursement for the Medicaid program to cover more individuals in order to improve maternal and child health. The administration encouraged states to offer demonstration projects to try to improve health care services without increasing costs.

Secondary to the increasing federal mandate to provide medical services to the poor and the rapidly rising costs of health care, states were discovering creative plans to cover their share of the Medicare dollar. Voluntary contributions by providers, special provider taxes, and payments to disproportionate share hospitals, all were altering the traditional philosophy of the sharing between federal and state government. Congress enacted Medicaid reform to prevent some of these excesses. This clearly pointed out that the way Medicaid existed, it encouraged both states and health care providers to spend as much as they could and provide as many services as possible so they would get more federal dollars.

Several major employers endorsed the idea of requiring companies to provide health insurance to employees or to pay into a government pool that would finance health care for the uninsured.

By 1992 it was obvious that health care costs were still rapidly increasing and that many Americans were still not able to receive care. All of the actions to stem the costs of health care and increase coverage had not solved the problems. Several proposals were considered to significantly change the American health care system.

The Bush Administration submitted a proposal to increase coverage of low income families by providing a government voucher to assist with purchasing commercial health insurance. Also included were malpractice reforms with the intent of reducing costs. The financing of the proposal was not clearly explained.

The Senate Finance Committee introduced a proposal to change the private insurance market so that it would limit the cost of purchasing health insurance and require insurance companies to provide coverage to all employees and their families.

Democratic Representatives Dingell and Waxman introduced a compulsory national health insurance with the government as the single payer. In their proposal the delivery system was reorganized under managed care. The program would have been financed by a Value Added Tax.

Senator Wellstone also unveiled a single payer proposal where the government would be the payer. His proposal would have eliminated copays, deductibles, and premiums. The financing would be through various tax increases.

The wide range of considerations prevented any agreement and no reform was enacted. It was also an election year. In 1992, Bill Clinton was elected pledging to reform American Health Care.

CONCLUSION

We have not effectively dealt with the health care in the United States because we have never agreed on health care policy. We have never answered two basic questions?

1) Is health care a right for all citizens?
Clearly, it is not a right until you are poor.

2) What should the individual's responsibility for health care be? In 1798 when the Marine Health Service was created, it was mandated that health care be provided to the seamen and we they were required to pay for the program by payroll taxes. This was done to protect the majority of citizens from the risk of disease. At several points in history, congress could have passed legislation requiring citizens to provide health care insurance for themselves but this was never done.

Special interest groups such as the AMA or American labor have been frequently blamed for blocking legislation, but it is unfair to direct blame when it has been because of a much larger political process. It is frequently the collective action of the most ardent opponents, on both sides of the issue, that serves to defeat legislation. Liberals have opposed national health insurance proposals because the plans were not generous enough and conservatives opposed the legislation because they were too generous. An incremental program or accepting compromise might have achieved a far different outcome.

The Medicare Catastrophic Coverage Act of 1988 was the first social insurance to ever be repealed by congress. It highlights one of the problems with implementing any national form of health insurance. This plan was opposed primarily by the citizens it was designed to help. A simple way to look at health insurance is that it pools the beneficiaries and resources in advance and then pays the bills. This serves to average the costs for all the beneficiaries. In health care a rule of thumb is that 20% of the beneficiaries receive 80% of the benefits. The corollary to this is that 80% of the beneficiaries pay more into the pool than they receive. If some percentage of the 80% of "healthy" people do not join the pool then the average costs will increase. Medicare is a unique form of insurance in that individuals "buy" into the program in advance and the fee goes up with income, to a certain point. The actual benefit does not begin until the individual is 65 and then the average beneficiary receives more benefit than they paid. The additional benefit is financed by current workers. The catastrophic plan failed because the politically active senior citizens did not feel the costs were worth the benefit. Had the program been allowed to work, it

might have solved some of the problems with Medicaid. When low income Medicare beneficiaries become very ill, they do not have the reserves to pay for the total costs of their illness. Without a catastrophic insurance program, their wealth is quickly lost to medical expense and they become poor and eligible for Medicaid. With a catastrophic program, the "pool" would pay for their medical costs and they would not become reliant on the federal and state government for their total health care costs. This experiment was not allowed to play out, so we do not know what the outcome would have been.

The government has become payer of last resort. When a critically ill individual arrives at the hospital they are going to receive care. If they do not have medical coverage then someone else is going to pay for the services. In the past the hospital and doctors would provide the care for "free" but in reality the cost was shifted to other payers. For hospitals to be eligible for funds, the Hill-Burton plan required services be provided to indigent people. Hospitals have administrative departments that struggle to find payers for people without coverage. This process is cumbersome and expensive. As managed care organizations (MCOs) negotiate contracts with hospitals to hold down costs, the contract also serves to prevent the hospital from cost shifting to the MCO. This will reduce the hospital's ability to provide indigent care and the government will be the payer of last resort. To support this point, the percentage of the population now covered by Medicaid is increasing.

Employers provided most of the health care insurance in the past but recent studies are showing the percentage of employers providing coverage is decreasing. With the current downsizing in American business it is becoming more and more common for individuals to change jobs. When health insurance is tied to the job the employee has to reapply for health insurance, if the new employer provides insurance. If the employee or a family member has a preexisting medical condition, they might be denied coverage.

The uninsured population in the United States is increasing. This group is composed of people who are:

- 1) Are too poor to pay for insurance but have not applied for Medicaid are not eligible
- 2) Have been unable to purchase health care because of exclusions based on pre-existing problems
- 3) Choose not to purchase coverage because they do not feel the benefit is worth the cost.

Unfortunately when any of these three groups become sick, they will very quickly use up their personal resources and the government (its taxpayers), will have to provide the funds.

To solve these problems we must implement compulsory insurance with universal coverage. There should be sliding scale deductibles and co-pays. The financing should come from payroll taxes on both employers and employees with a sliding scale contribution based on income. The self-employed need to contribute a greater portion of their coverage, but this should still be based on a sliding scale. The poor should be provided insurance coverage so they can get the same care as others and

not be dependent on a separate system of care. When they become employed, their care should not change, they should now pay a portion of their coverage..

On the question of a single payer or multiple payers, a combined approach should be taken. Rather than dismantling the insurance industry, a minimum federal benefit could be defined and then competition allowed to work.

The provision of medical care is already rapidly being reformed. Managed care with its capitated reimbursement holds promise and there is need to involve patients, providers, payers, and government in the decisions of managed care organizations. Both long term and short term costs must be considered to maximize health and provide quality services with regard to available resources. Fee-for-service and managed care systems can coexist and compete. Reimbursements for fee-for-service care should be based on a national average with regional adjustments.

Health care is a complex issue. Compromise and conciliation will be required. Very little of this has been demonstrated in this session of congress. Prognosis for cure is not likely in a year divisible by 4!

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